CONNEMARA PUBLIC LIBRARY
20 NOV 1937
MADRAS

JOURNAL OF SOUTH INDIAN MEDICINE

(*Incorporating the Bulletin of the South Indian Medical Union*).

VOL. IV OCTOBER 1937 No. 7

HAEMATEMESIS.

By

T. SATAKOPAN, M.D.,

Government General Hospital, Madras.

Conditions which are associated with vomiting of blood are many. But often the blood that is vomited is trifling in quantity being just a speck or two or some streaks. In most of these cases bleeding is not from the stomach. It generally comes from swallowing blood that has come out of other regions, for example, from the nose, or the gums. Sometimes blood which has been coughed up is swallowed and vomited later It is proposed to deal here only with such conditions where the bleeding is serious. They are not very many. They are chiefly associated with gastrostaxis, duodenal and gastric ulcers and cirrhosis of the liver, (French). Though elsewhere bleeding is a prominent and serious symptom of ulcers of the stomach, it has not been our experience here to find bleeding so frequent. It is unnecessary to deal in detail with the various causes. I merely propose to review a few cases of serious haematemesis.

The case which comes very prominently to my mind is that of a child of four years. Pellets of blood were found in the vomit with severe pain in the abdomen. One night there was severe vomiting and the vomit contained very much of fresh blood. Excepting for the alarm associated with the sight of blood, there was nothing very serious about the child. The only prominent symptom was the continued severe pain in the epigastrium and round the umbilicus. There was a repetition of the bleeding from the stomach and all of a sudden it was noted that the child passed urine which was almost pure blood. The haematuria was severe and it was

mistaken by an experienced physician for acute nephritis. But in the course of a few days the haematuria stopped and the urine was clear. The child was treated with Adrenalin by mouth and by injection. The child got well and he is now grown into a boy without any recurrence of the bleeding though from time to time he complains of mild pain in the epigastrium and round about the umbilicus. He has now and then oedema about the eyelids. He responds very promptly to calcium. It is definitely a case of Purpura of the Werlhof type.

The second case is that of a young man of thirty years of age. I was called in to see him because he was vomiting blood. The history was unmistakably that of chronic duodenal ulcer. He was off and on under treatment with alkalies which relieved the pain. This time the alkalies failed to give such prompt relief. While under treatment there were repeated attacks of severe and profuse haematemesis. Energetic measures were adopted. He was promptly put on morphine and taken off feeding by mouth except pieces of ice to suck. But as the bleeding was persistent, the stomach was washed with iced water without results. There was no facility for transfusion. The surgeon who saw him refused to interfere. The patient died.

The third case is that of a man of forty years. He had a severe degree of diabetes. He was brought to the hospital with severe epigastric pain which was taken for an early symptom of coma. While under treatment for coma he started vomiting blood profusely. The usual method was adopted including gastric lavage with iced water and transfusion of blood. But the case ended fatally.

The last case is that of a lady about menopause. I was called in to see her for the complaint of giddiness. There was nothing noteworthy to account for this giddiness. There was no cardio-vascular trouble. While she was in bed, she was troubled with much nausea and retching. One day she started vomiting and the vomit consisted of much mucus with a fair amount of clotted blood. Just before this attack of giddiness and vomiting of blood she had a very slight menstrual flow after an interval of 15 months. Whether this could be an instance of so called vicarious menstruation is difficult to say. She was suspected to be suffering from malignant disease of stomach. X-ray investigation did not confirm this. The lady is living and well after nearly 2 years without any recurrence of haematemesis. The giddiness was possibly the result of a vagovasal upset with an associated chronic gastritis causing hæmatemesis.

It is not commonly known that gastritis could be responsible for very unpleasant degrees of vertigo. I have had recently a fair number of cases of severe giddiness. The ages varied from 35 to 55 years. Three of these had some degree of arteriosclerosis, though except in one case, the arteriosclerosis was not advanced. There were no cardiac changes to note. And in the absence of other incriminating evidence these cases were treated for gastritis. All the cases responded very promptly to the appropriate treatment.

In discussing these cases one is compelled to reçognize that haematemesis is not a very common condition here. And while serious bleeding is due to the four conditions mentioned above, one should also bear in mind that conditions so uncommon as purpura in children and chronic gastritis are fairly likely causes.

Text books mention portal obstruction chiefly due to cirrhosis of the liver as a common cause of haematemesis. But in a very large number of cases of cirrhosis of the liver that one sees in this country, it is not often that one elicits a previous history of haematemesis. Many of these cases of ascites in this country may not be due to cirrhosis of the liver. But while many of them show evidence of portal obstruction haematemesis does not seem to be a part of the picture at any time.

The diagnosis of the cause of haematemesis is not always easy. The chief point to decide is to know if the bleeding is due to lesions of the stomach or whether the bleeding be a manifestation of a general constitutional disturbance. In the great majority of instances the bleeding is chiefly due to lesions in the stomach or duodenum, and these are the most serious and frequently fatal. Haematemesis which occurs in the early stages of cirrhosis of the liver or other vague causes is rarely serious or fatal. From the point of view of treatment and prognosis, it would be helpful to know whether a serious bleeding is due to the bursting of a fair sized blood vessel or whether it is due to a general ooze from a widespread area of the mucous membrane. Gastroscopy might be very useful for this purpose in experienced hands. But it is obvious that in the serious state in which one finds the patient, it will require some courage on the part of the surgeon to undertake gastroscopy without risk to the patient.

The treatment of haematemesis is not very satisfactory. While mild cases and a large number of severe cases recover without much trouble, it must be admitted that where the haematemesis is severe or repeating, many of the methods usually adopted seem to be of no avail. When the

physician finds his attempts fruitless and the patient is rapidly slipping down it is natural that the physician or the relatives of the patient should appeal to surgery for help. Except in the hands of a few specialist surgeons, immediate operation for haemetemesis is attended with grave risks. And there are few surgeons who will undertake the responsibility to operate in the presence of severe gastric haemorrhage. Therefore, in spite of defects, the treatment for haematemesis is still mainly medical. And it is a matter for relief that modern methods have largely contributed to make this more satisfactory. The readers are familiar with the usual methods of treatment. Raising the foot of the bed, an initial dose of morphine to soothe the nerves, cutting out all feed by mouth, pieces of ice to suck, ice bag to the abdomen, injection of calcium and haemostatic serum and lavage of the stomach with iced water. Unfortunately none of these measures is really helpful in severe cases. For, in severe haemorrhage, the chief indication is to maintain a fair level of blood volume. Blood transfusion therefore in recent years has been the means of saving some lives where otherwise death would have been certain from haemorrhagic shock. But transfusion is rarely needed as a routine and it might even provoke further haemorrhage if done while haematemesis is still on. It is chiefly indicated when the pulse is fast, blood pressure is low and haemoglobin is below 50% (*Witts*).

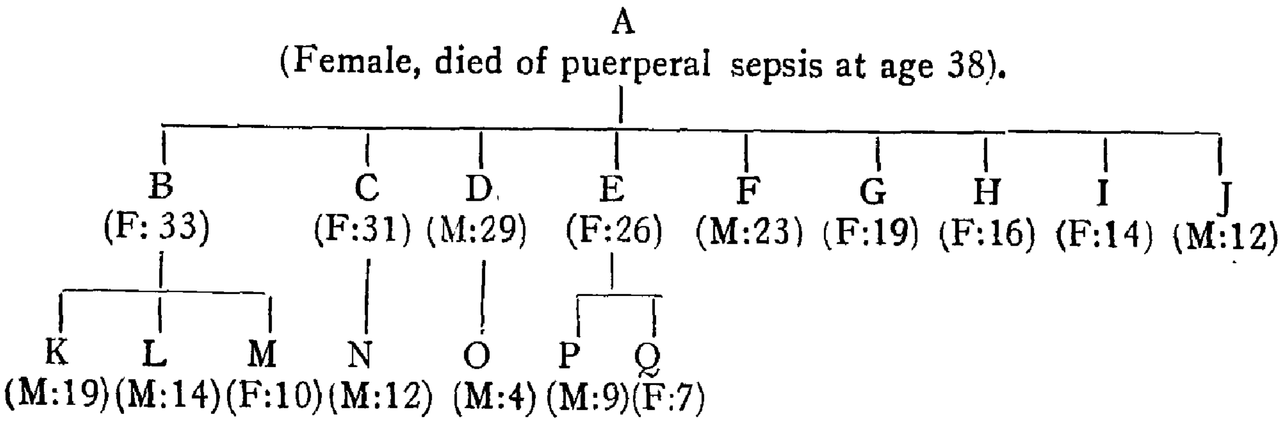
The real contribution to the more successful treatment of severe haematemesis is that of Meulengracht. From starvation and dehydration the treatment has swung round to keeping up the general condition of the patient by feeding him from the beginning. The later work of Blalock on the effects of haemorrhage in animals supports the view of Meulengracht. He reports magnificent results from his method. And with slight modification towards caution, Witts reports equally good results. We are aware that this method has not yet given such favourable results in the hands of some who have tried it here. Better results may follow greater experience.

MIGRAINE.

By

A. V. S. SARMA, M.B.B.S.

Points of interest regarding migraine that struck me worthy of record are described here. I have studied three generations as represented below :—



Of these A, B, C, D, E, F, G, and H get migraine, and unilateral limb pains. K, L, M, N, O, P and Q get unilateral limb pains D and F exhibit also unilateral sweating of the body, and sometimes along one limb only. D exhibited once asthmatic symptoms.

Etiological factors

That the disease is hereditary is proved. A's brother died of acute phthisis. The disease does not seem to be transmitted only through the female members of the family. The male members also transmit the malady to their offsprings. The following conditions bring on an attack :

1. Neglected hunger.
2. Fatigue, physical and mental.
3. Excessive sexual indulgence.
4. Exposure to cold.
5. Constipation.

Symptoms.

The first point that is worthy of note is the occurrence of pain along the same nerve (" sensory aura ") of a limb.

The pain is slow to develop and generally manifests itself towards the evening and persists for a couple of hours only. There is nausea prior to the beginning of the pain in the limb. A headache does not seem to succeed these events at all. Sick headache occurs by itself or alternates with limb pains. Sometimes the latter only occur without any sick headache.

The second point that is specially observed is sweating on one side of the body only; this occurs independently of sick headache or limb pain. The sweating part is always on a higher hydrostatic level.

The third point is perspiration of a part of a limb independent of any other manifestation.

The fourth point noted is the chilliness, traction, and pain of the testis on the side of the painful limb felt by some male patients.

Treatment.

A method of treatment devised by sufferers to abort a limb pain is severe constriction applied by a rubber band or rolled up cloth to the proximal part of the limb, and complete rest in bed after a cup of hot coffee.

Accepted lines of treatment including the modern administration of ergot derivatives are well known.

The following has given me good results :—

R/

Dextrosol	℥ iii
Sodii Bicarb	℥ iii
Aspirin	gr. xv
Caf. Citras	gr. iii

Ft. Pulvis Three. One T.D.S.

Discussion regarding Pathogenesis.

" He (Spitzner) attributed the attacks of migraine to temporary unilateral hydrocephalus, from temporary plugging of the foramen of Munro...... This theory is the only one based upon pathological evidence..." (James Collier.) There may be a congenital defect in the structure of the cerebral cortex or its arterial supply that might predispose to this disease.

Migraine has been compared to epilepsy and dysfunction of the erebral cortex has been incriminated..

Errors of refraction have been unduly exaggerated in the genesis of this disease. I have corrected very carefully the refraction errors of D and F of my small series without any results. Strain of the eyes without the aid of the glasses prescribed always started an attack of migraine in both D and F.

Arterial spasm of cerebral arteries has also been suggested as the cause. Probably the fault is in the construction of the cortical arteries. A similar proof is substantiated as the essential lesion in Raynaud's disease (Sir Thomas Lewis).

" It (migraine) has been held to be the result of a temporary condition of intoxication from digestive, metabolic or internal secretary disorder, which recurs periodically. There is little evidence in support of this view......" (James Collier). I feel that a summary disposal of these factors is very unreasonable Migraine generally makes its first appearance after puberty, and disappears in old age. These are the two ages of human life where adjustments in endocrine gamut are made by Nature in the body. Pregnant women usually enjoy freedom from this disorder. Women suffer the severest headache before a period. A series of sick headaches are relieved in a patient (D) after seminal discharge. These facts suggest the endocrine side of hemicrania. In F, I have attempted to estimate the hepatic sufficiency by a method using methylene blue as a means of dye elimination—(the details of this technique will be elaborated on another occasion)—and found it much below par. The urine of this patient has always been acid to litmus at the commencement of every attack. All the members of the above series have no sugar or albumin in the urine. I am convinced that acidosis has thus a part to play in the causation of the malady. F in this series is a medical student and has tested his saliva and tears too at the commencement of an attack and found to his information both secretions acid to litmus. Further this particular patient has ascribed some attacks to unappeased hunger, and sometimes to neglect of nature's call in time. Hepatic insufficiency, acidity of urine, the general appearance of the first attacks after puberty, should compel our attention either to the adrenal cortex, or the anterior pituitary or to both.

References.

1. A system of Clinical Medicine—Dr. T. D. Savill, M.D.
2. Practice of Medicine—Dr. F. W. Price, M.D., F.R.S.
3. B. M J., 23-7-1932: Raynaud's disease—Sir Thomas Lewis, M.D., F.R.S.

AN INTERESTING CASE OF "EPILEPTIC FITS."

DRS. P. S. VARADARAJAN M.D., M.R.C.P., & N. NATESAN L.M.S.
Government General Hospital.

Name: V—Age: 16—Sex: Male—Hindu Brahmin.

Complaint.—Convulsive fits confined to the right half of the body.

Duration —Since birth.

Periodicity.—Irregular, but may be said to be once in 7 to 10 days, though latterly the interval between the fits was nearer three weeks than one.

Previous personal History —Full time child at birth—Labour Duration. etc., nil abnormal—Subjected to infantile convulsions even with apparently no or trivial causes—Single child—no history of abortions—Breast fed till 2 years.

" Milestones of development " retarded.

Family history —Mother alive. Father died early of causes that have no bearing on the present complaint—No history of V. D.

Mother has six fingers on each hand.

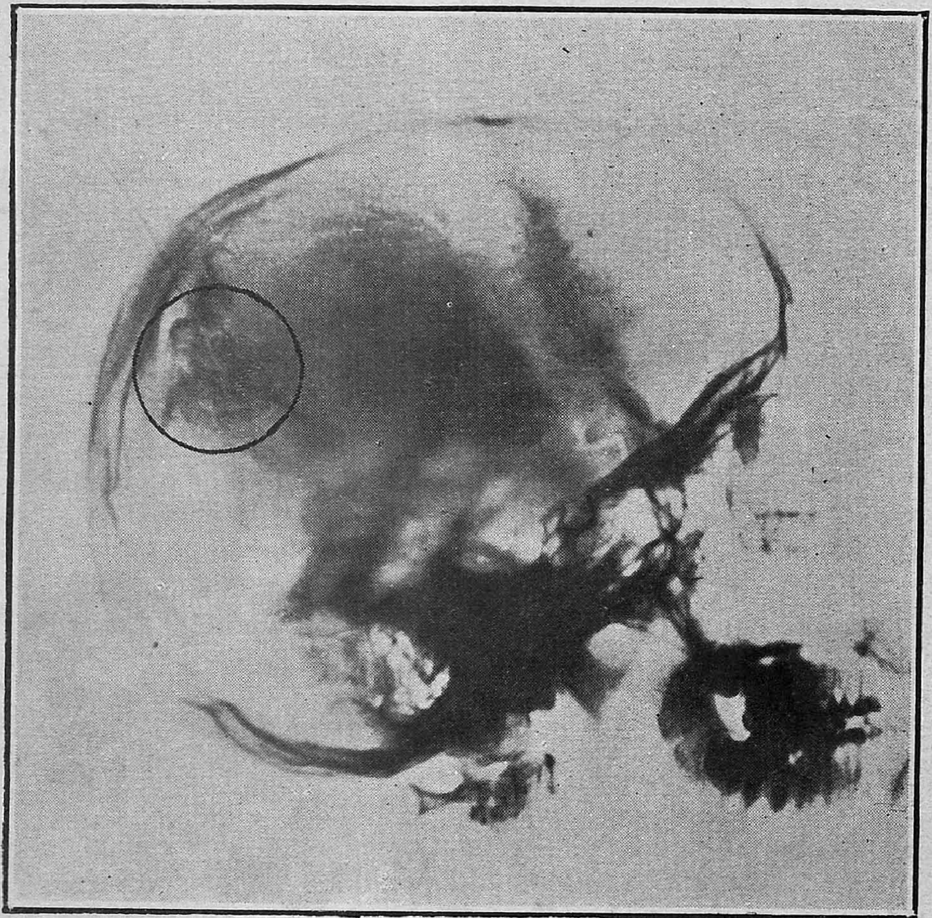
Examination.—Fairly nourished—Physical growth including sex development up to the average of his age. Very distinct mental retardation. Intelligent quotient : ½. The boy has syndactyly in both the hands. The thumbs are free. The four inner fingers are grouped in twos. No other stigmata of degeneration.

Gastro-intestinal tract.—Nil abnormal. It has been noticed that there is a very distinct evidence of intestinal auto-intoxication and torpidity of the liver prior to some attacks of the fit.

Central Nervous system.—Locomotion : slight dragging of the right limb (but no spasticity)

Speech.—Monotonously uniform as if the patient did not hear his own speech. No evidence of any form of classical speech defects.

CONNEMARA PUBLIC LIBRARY
20 NOV 1937
MADRAS



LATERAL VIEW OF THE SKULL.
(Note the encircled area—" the calcified angioma-Venosum ")

CONNEMARA PUBLIC LIBRARY 20 NOV 1937 MADRAS

Cranial nerves.—Not affected.

Reflexes.—superficial (including abdominals) and deep—nil abnormal. Babinski—Flexor.

Power.—Right hand grasp weaker than the left, though the patient is right handed by instinct and habit.

Sensory and cerebellar system (*afferents and efferents*).—Show no abnormality.

Fits.—Most fits are confined to the right half of the body. Consciousness is retained though some of the nocturnal fits are not remembered by the patient the very next day. At times the fits become generalised throughout the body and then in no way differ from Hautmal of " ideopathic " Epilepsy. Tongue biting, frothing from the mouth and even voiding urine voluntarily have been noticed. Patient suffers from no evidence of increased intracranial tension (headache, vomiting and visual defects). Other systems normal. The skin bears no evidence of *birth marks* of any description or *adenoma sebaceum*. Nor are there any scars of injury due to falls, etc.

Radiogram of the skull :—(A. P., lateral and stereoscopic) Shows a patch of opacity in the right parieto-occipital region. The contour, etc., of the opacity makes it appear to be one of calcified blood vessels. Sella turcica appears to be normal. No " beaten brass " appearance. (See Plate)

C. S. F. normal in all respects. W. R. Negative.

Blood.—W. R. and Kahn—Negative.

Patient was accommodated for a few days in hospital. He was given small doses of Luminol and also Calcium Gluconate (intravenous injections) along with ultra-violet baths and subcutaneous injections of small doses (10 units) of Callop's Parathormone with the hope that the process of calcification may be intensified.

Disposal.—Patient was under observation in all for 5 weeks. He suffered from no fits during that period.

Diagnosis.—It would appear that the condition is one of angiomatous malformations coming under the category of calcified angioma venosum. These are developmental angiomatous malformations rather than neoplasms. The fits appear to result from slight

vascular accidents, pressure or irritation in association with increased intra-cranial pressure (Any relation to auto-intoxication !)

Discussion:—(*a*) The patient appears to have had infantile convulsions from birth with very slender causes. The attacks passed on to "epileptic" attacks as he grew from infancy to childhood. Obviously the infantile convulsions were in themselves epileptic attacks (this is in accordance with the teaching that infantile convulsions fall into one of three categories :—

1. Those that are truly neurogenic with or without any organic neurological evidence, to be regarded as "infantile epilepsy" as they are almost-certain to be epileptics in later life.

2. Fits induced by reflex peripheral or toxic causes inheriting as they do a neuropathic diathesis—a functional weakness of the central nervous system due to inheritance of "poor nerves"—may grow out of it quite well.

3. Fits that are spasmophilic in nature due to calcium deprivation —quite amenable to treatment and can be eradicated even early in life.

(*b*) Polydactyly in the mother and syndactyly in the patient raised a doubt in one's mind if this be one of those pituitary dyscrasies of the type of Lawrence Moon Biedl Syndrome. The other concomitants of the syndrome *Viz.*, genital hypoplasia, retinitis pigmentosa, other evidence of Pituitary dysfunction and changes in sella turcica are prime factors against the diagnosis.

(*c*) The very definite history of the one sided nature of the fits suggested an organic cause (though the occurrence of Hautmal with an organic cause is quite in order). An alternative diagnosis of meningeoma has been suggested. But these are true neoplasms and the manifestations are never in such early life. Though growing at an extra-ordinary slow pace it is difficult to visualise the uniformity of symptoms in sixteen years and also the lack of erosion of the bone.

(*d*) The age of the onset, the situation, the course of the illness, the size and shape have suggested to the writers the diagnosis referred to above, *viz.*, angiomatous malformation (intracranial) being a specimen of calcified angioma venosum of the cirsoid type. It would have been helpful or even corroborative in the diagnosis to have noticed on the same side of the face congenital naevi, tortuous retinal vessels, etc. But the absence of these symptoms do not rule out the diagnosis ventured upon.

(*e*) Developmental defects are often associated with stigmata of degeneration (the presence of syndactyly) and close examination of epileptics may reveal defects in a larger percentage of cases than hitherto thought of (compare the presence of epilepsy with adenoma sebaceum, ependymal tumours and skin manifestations).

(*f*) "The grape shot" calcium therapy (Ultra-violet bath, High calcium diet, Calcium Gluconate and parathormone injections, was purely an experimental measure and has not the sanction of orthodoxy behind it. As the patient was under close observation no untoward effect was apprehended. Moreover, it is hoped that the natural process of calcification in the unwanted tissue is augmented by this means. Our thanks are due to the Barnard Institute of Radiology for the very excellent skiagrams and their elucidation.

REFERENCES:

Diseases of the Nervous system (Russel Brain—1933 Ed.)

Text Book of Pathology (Boyds—1934 Ed.)

AYURVEDA, SIDDHA AND UNANI,

NOT TO MENTION HOMEOPATHY, BIOPATHY, NATUROPATHY, OR FAITH CURE.

(By VEDIAN)

"I would advise you, however," he (Prof. Eason) pointed out (says the editorial in the Hindu of the 26th October) "that throughout your professional career you should keep your eyes and ears and especially your mind open to any new trend of thought or method of treatment, however unorthodox its source. Try it out fairly and if, after due enquiry, you find it sound, make use of it." This is very sound advice, says the editorial and should have further said, that it was by such a policy of constant observation and open mindedness, of ever searching for new truths and assimilating them, while discarding old beliefs and knowledge proved untrue by experience, that modern Medical Science has developed from Ayurveda which travelled from India and Arabia to Greece and so to Europe.

Ayurveda in its times was a medical science and not a mere "system" of medicine as it has become in these days. Modern Medicine is a universal science and not a system or sect called Allopathic. Whatever theory of phenomena of health or of disease that best explains it, whatever method of prevention, investigation or treatment of disease that proves of best value, is incorporated into the science of Medicine, irrespective of the country of its origin, or the status or profession of the originator. If more than one theory, or method of investigation, treatment or prevention is found suitable all such are adopted by the Science, and used by its practitioners according to their individual taste or prejudice. Medical science does not refuse to accept any of these just because it happened to be first pointed out or advocated by a particular nation or individual.

The universality of Medical Science is so obvious and the instances of its having incorporated methods and materials of healing of proved value from every source are so numerous. Cinchona the well known remedy against ague, and from which Quinine is extracted was taken from the aboriginies of South America and many must have read the fascinating story of its introduction into Europe that appeared in a Sunday Hindu some time ago. Just a few years ago Dr. Bhandarkar a Madras physician did investigations on a Mangalore herb and popularised its use for Diarrhoea and allied conditions and the Health Department of Madras Government gave it an extensive trial in epidemics in the South. Col. Chopra is well known for his researches in indigenous drugs on modern lines.

As with materials, so with methods. Sweating, purging and enemata to which Charaka-samhita devotes so many chapters have a proper place in modern Medicine in an approved form and for suitable conditions. So have bloodletting, venesection, leeches been retained from ancient practice of Medicine. A few years ago, Dr. Gananatha Roy Sen gave a series of lectures at the Y. M. C. A. here on Ayurvedic surgery showing the instruments in use in Ayurvedic days. Several of the operations he mentioned are performed by the modern surgeons though with improved instruments and technic. Those lectures only proved the truth that modern science does not discard principles that stand the test of modern knowledge, just because those principles were discovered by the ancients of any particular country, though it might improve on them. A stone in the urinary bladder deserves removal according to Ayurveda. Modern science does not refute the principle just because it is ancient, though it improves the technic.

All these facts should surely convince one that Medical Science is as it ought to be universal. If some call it Allopathy (allos, different; pathos, disease—aiming at producing conditions in the body different from those of the disease) it is only to justify their own unreasonable claim to be a sect. It was Homeopaths I believe with their main principle " likes cure likes " (homoios, like; pathos, disease. Presuming that drugs which produce in healthy persons symptoms like or similar to those of the disease will cure the disease), that first dubbed Medical Science as Allopathy.

In fact it is extremely difficult for a scientific mind to comprehend the possibility of sects in Medical Science. Chemistry, Physics, Biology, Mathematics have no sects, cannot have them. How can unfortunate Medicine alone have them ? Anatomy, Physiology, Chemistry and Physics being the same all over this planet at least, Medical Science must of course be the same in spite of the diversity of nations, religions and languages.

It is therefore impossible to believe in the farce the Madras Government is enacting in the three acres in Kilpauk, of teaching not one or two but three " Systems " of Indigenous medicine, in three languages, not to mention the fourth " System " taught in a miniature style presumably to justify the title of " Ubhaya-Vaidya-visharada " or something like that arrogated by some of them.

Much is made of the advice of Prof. Eason to students and opportunity taken to advise " Allopathic " medical profession on its duty of keeping its eyes and ears open. But why in the name of Goodness heap up all this coal on a Newcastle train. Not only have the eyes and ears of the Medical profession always remained open, but they have been kept widely open, and

their present development which makes them independent of the shelter of sentimental psuedo-patriotism, is simply due to the fact that they have been kept so widely open. Not only have they kept their eyes and ears open, but they, at least those that have made Modern Medical Science, have gone out of their way and peeped behind closed doors into the mysteries of nature.

Medical Science is not a book religion, bound by texts written thousands of years ago and dependent for its glory on the accidents of geography or political history. It is a rational science open to investigation and improvement. If investigation and improvement were imported into the three acre sporting ground of psuedo-patriotism in Kilpauk, that also would soon evolve into a useful branch of the Madras Medical College.

Appeal is made to the patriotism of the President of the Congress to patronise indigenous "system" of medicine. If and when Purna Swaraj comes, will these "patriots" similarly appeal to the War Minister to equip the army with indigenous arms like bows and arrows instead of with the latest Western arms, without being afraid of being locked up in the other medical institution in Kilpauk !

In these days of transition to independence, one has to be very particular and clarify one's ideas of patriotism which is neither an indolence content with singing songs of ancient glory, nor a mere hatred of all that is foreign. Thinking of the best interests of the country and working for them is patriotism. Japan found caste distinctions detrimental to the growth of their country and even the proudest caste amongst them, the Samurais gave up their caste privileges. Patriotism made them modernise their army and navy nor did patriotism come in their way of adopting modern sciences.

The word 'Medicine' and 'a medicine or medicines' are too often loosely used, forgetting that the former means science of Medicine and the latter drugs. Writers waxing eloquent on the virtues of certain Indian medicines, suddenly conclude that Indian Medicine is superior to "Allopathic" medicine. As stated above modern Materia Medica is open to all material found useful after rational tests, even if they do not prove more useful than materials already known. And the glory of the country would be greater, if we investigate all the indigenous herbs and drugs reputed to contain some very potent remedies and make the world richer in its Materia Medica.

Appeal to patriotism to encourage Ayurveda so that indigenous drugs would be used and import of foreign drugs would be diminished is also not sound. A sounder advice would be for the encouragement to chemical industries in the country or even starting of newer and larger chemical industries by the Government.

Two famous Vaidyas, who have been conducting a school and hospital of Ayurvedic Medicine in another city and who they told me are doing some research work also, called on me and gave me incidentally the benefit of their experience of and opinions on Ayurveda and Modern Medicine. They had spent two and a half hours at the Indian Medical School; which really ought to be " School of (Ancient) Indian Medicine ". Just as the main point of my enquiry in our conversation was to understand why they considered Ayurveda a distinct science opposed to modern Medicine, they on their part were compelled to enquire into the genesis of the triangular farce at Kilpauk. I shall endeavour to translate literally what the spokesman of the two said to me. " How does Siddha become a distinct science from Ayurveda ? Let us go step by step. Is Sareeram different in the two ? The Doctor said ' No '. Is the Nidanam different ?" ' No'. (Sareeram is Anatomy and Nidanam, Pathology.) Is the Chikitsa (treatment) different ? The Doctor said 'yes, we use Bhasmas mostly.' I said the bhasmas come under our heading of Rasayanas. The Doctor said ' But our tantram (method of preparation) differs. ' I said as we agree in all upto the stage of Tantram or even of Bhasmas and differ only in the last, do you think it is justifiable to make Ayurveda and Siddha two different systems ? In the end the Doctor agreed that it was a political stunt. The Committee wanted to please the Mohomedans, the Telugus as well as the Tamils, and so gave each an importance by creating three different sects. Even Unani is different more in the *via media* of its literature than in anything else.

It is over a dozen years that the Indian Medical School came into being, and at least two medical men qualified in Modern Medicine are on the staff of its hospital. If these medical men had discovered anything really worthy of adoption by the world for the benefit of mankind, they could have certainly found space in some of the numerous medical periodicals especially if it is something of superior value. If " Allopathic " periodicals were found unsympathetic, surely the Hindu, the adviser of " Allopaths " would have obliged them.

The Hon. the Minister for Public Health has the courage to abolish Medical Schools for the sake of uniformity of Medical education, and Medical Profession. But does mere abolishing of these " allopathic " schools acheive the aim ? The future battles will be between the L.I.M's and the M.B B.S's. Patriotism at this stage is highly adulterated with psuedo-patriotism and a popular ministry dependent upon this is not likely to touch anything like the Indian School of Medicine. And Dr. Rajan's saying that people could not be forced to believe in a particular system by means of legislation is only in tune with its surroundings.

But if Government be not merely the public's servants, but at least partly their leaders then it would be their duty to consider something more than the public's belief. Can Ayurveda as it stands be called a Science? If by research and use of modern equipment it be brought upto date, will it still remain a separate science? If people cannot be forced into beliefs, can they not even be persuaded into them? How many do really believe in Ayurveda as a science, how many resort to it as a last remedy and how many out of mere superstition and awe for secret remedies?

In the first place even if beliefs that are wrong cannot be changed by legislation, a Government need not so to say legalise wrong beliefs by maintaining institutions that teach them and incidentally cast a net to ensnare credulous and innocent youth into them.

For the satisfaction of people who sincerely believe in Ayurveda as a science, it could be very well taught as an ordinary or optional subject for the M.B.B.S., adding two chairs to the Medical College, one for Tridosha Pathology and one for indigenous Pharmacy. This will in the first place ensure public safety. For the graduates will then have knowledge of the whole medical science, and will yet have the liberty to use the knowledge of Ayurvedic remedies. For it has been found by experience, dangerous to give only partial knowledge of Medicine and let loose such men on the public. For it prevents patients from getting the proper treatment in time to save their lives. The Kilpauk School does not teach Bacteriology as seen from its prospectus. Is Government justified in these days to impose these men without any knowledge of the most modern branch of medical science on villagers as Rural Medical Officers or worse still as in charge of bigger dispensaries or hospitals. Some may sincerely or through their psuedo-patriotism believe in Ayurveda but why should the larger majority suffer for this? As to how many really believe in Indigenous System could be apparent by seeing how much fall in attendance at the "Allopathic" hospitals has taken place since the opening of the Indigenous Systems Hospital at Kilpauk.

A better course still for the Government to adopt would be to maintain the Kilpauk Hospital as far as its Medical section is concerned, and utilise it for a course of post-graduate training and diploma in Indigenous Systems. This will assure perfection of knowlege in the practitioners, it will not burden the ordinary students for M.B.B.S., and it will keep believers in Indigenous System satisfied and at the same time completely safe from not getting proper treatment in time for want of the Government stamped practitioners being imperfectly trained.

JOURNAL OF SOUTH INDIAN MEDICINE
OCTOBER, 1937.

MADRAS MEDICAL COUNCIL.

The present constitution of the council with its overwhelming preponderance of nominated and elected officials has always been the subject of criticism from the medical profession. It is now nearly twenty three years since the Medical Council Act was passed, and though many striking changes have taken place in the profession, the Act has not been amended in any important way. The main purpose of the Act was to prevent qualified men associating with practitioners without the necessary training in modern medicine. It was also the aim to safeguard the interests of the fully qualified practitioner. The Council as now constituted serves neither of these purposes. With the inception of the Indian School of Medicine and the employment of its licentiates in public institutions, it would be absurd to expect that qualified medical men should not work as consultants or collaborators of those who practise indigenous medicine. As for the safeguarding of the interests of the profession the only privilege that might be useful to some practitioners is that of issuing certificates of health to public servants. With the necessity for further scrutiny of these certificates in the shape of countersignatures or the present practice of second opinion of officials, the privilege is difficult to sense. We are not concerned here whether this countersignature or its equivalent—the second opinion is right or avoidable. But we wish to point out that any advantage that the practitioner might be supposed to derive by being on the Register is more or less imaginary.

One other purpose which is said to be served by the Medical Council is the general control over the maintenance of standards of Medical education. Whether this function has ever been adequately discharged is beside the

point. But with the inauguration of the Medical Council of India, educational functions are being discharged by this body so far as University standards are concerned. There is no purpose in provincial Medical Councils also having a say in this education. In fact it is unreasonable that Universities should have two bodies to satisfy about their standard of Medical Education. The Madras Medical Council can therefore only control the standard of education which is below the University, in other words only Medical Schools which teach up to the Licentiate standard. But happily, this two-standard education in Medicine will cease to exist in the next few years. We therefore think that the Madras Medical Council can divest itself of this duty of controlling standards of Medical Education.

There thus remains only the function of looking after the correct standard of the practice of medicine. To be more direct the Council should consider it its main duty to see that the standard of medical ethics in this province is as high as it should be. The suggestions to amend the existing Act should therefore take into consideration the limited rôle and the legitimate functions of the future Medical Council. Its activities towards medical education would be nil or negligible. There is therefore no reason why, educational institutions should form an important part of the framework of the council in future. The duties of the council would be chiefly to look after the character and standard of medical practice of the province; and the practitioners would thus be its chief concern. It is therefore essential that the council should be so constituted that the practitioners have the largest say in the ordering of its activities. It is only then that the bulk of the practitioners whether unofficial or official will come to have greater confidence in the integrity and impartiality of its decisions on occasions where the council has to exercise its disciplinary control over the practitioners. One would think that with such simplification of its duties and therefore of its construction it would be easy to mark out the electorate or the institutions which should contribute to the formation of the council. We wish it were. But there are some irrelavent complications which nobody seems to

be willing to abolish. There are at present groups and ostensible group-interests. Their existence is publicly regretted. Various schemes are suggested to eradicate the evil. But on analysis each batch of suggestions carefully nourishes the delusion of the dominant interests of a particular group. The licentiates resent, and rightfully, the idea of formally recognizing the existing state of affairs in the Medical Register of the Province by having three groups. It is proposed to abolish this in the future Council. It is very good indeed. The profession gains immensely. But when it comes to the constitution of the council, the Licentiates remember the fact that they form the vast majority of practitioners—and only that! But they obviously forget that they are practitioners just the same as graduates and others The council is to safeguard and control the interests of the practitioners as a whole. The graduates and the foreign qualified practitioners in turn feel nervous that being in a minority their interests might suffer if they are not represented in sufficient numbers on the council of the future. In the present council of fifteen members there are three elected non-official practitioners, and one or two nominated non-officials. Have the interests of the practitioners suffered by these arrangements? We doubt very much; except the feeling that there are only a few non-official practitioners—Licentiate or otherwise.

We welcome a unified Medical Register. But it is not a step, not even the first step in the betterment of the profession The first step is for the practitioners to feel that their interests are common—be they graduates or licentiates, Indian or foreign qualified. And are not the interests common? The difficulties and handicaps are common to all. The ethical standard is common. Their grievances against Government and its medical men are common. And with all these common interests, is it too much to expect of them to work together in most spheres of professional affairs? On the contrary, in actual day to day work they work together and very harmoniously too. And what about their most important interest—namely their duties to the State and their service to the suffering public? We fail to see any difference between the licentiates and others. With such common

interests and purpose, with a common register, could we not also hope for a common electorate. Already we hear of groups putting forth claims to safeguard their interests. We are disappointed to know this. It is certainly soothing to individual vanity to be a member of this council. But to proclaim that if the graduates are not in large numbers, or if the licentiates do not predominate, the profession or the practitioners would suffer is mere indulgence in flighty talk. Such sentiments, if honest only perpetuate the differences which we all deplore.

There is talk of reservation of seats. Is this in earnest of increasing nationalism or of that extremely confused attempt at socializing medical relief in this province? To our mind it spells like the tacit acceptance of the existence of depressed communities in the medical profession. Fatalism!

CORRESPONDENCE.

In these days when a popular Ministry is in office wielding far greater power than previous Ministries, the Medical profession should take the opportunity and agitate for reforms in the profession. Such reforms should aim mainly at better service to the public. It is true that a member of our profession is the Minister for Public Health. That does not mean that the Medical Associations and Journals should keep still after expressing a pious hope that the Honourable Minister will do the needful. The opinion of the profession should be voiced in no uncertain manner.

What are the causes of the appalling death rate as compared with other civilised countries? There is only one major cause *i e.,* quackery. Next comes the tremendous ignorance and credulity of the lay public, the educated section of it not being entirely exempt. The latter cause contributes to a high rate of mortality only because there are quacks to cheat the credulous. Urgent legislation is necessary to ruthlessly put down all kinds of quackery. Compulsory teaching of Hygiene in schools should be introduced so that the Public Health Department may have the intelligent co-operation of the people in the prevention of diseases.

So far as allopathy is concerned the problem of quackery is comparatively simple. Any one who professes to practise allopathy without possessing a recognised qualification can be penalised. In this category ward boys and compounders in Government service and ex-ward boys and other qualified compounders are the worst offenders. Instances are not lacking where medical officers in charge of Government and Local Fund Dispensaries make use of their compounders for the administration of anaesthesia even when other qualified medical men are available in the localities concerned. Professional bone setters and barber surgeons do a great deal of harm. But in the other systems one has to admit that in the absence of recognised qualifications (L.I.M. etc. being of recent origin) it is indeed difficult to distinguish between the genuine and the spurious article. There are quacks among Ayurvedic, Siddah, Unani and Homeopathic practitioners. Then there are the barber and other unqualified mid-wives who work havoc in the villages and in some towns too.

The Honourable Minister for Public Health while declaring the indigenous systems of medicine as arrested sciences, has on several occasions promised to encourage these systems. But he has not promised to encourage quackery. The following plan with suitable modifications will, I think, deal with the problem of quackery:—

Every individual who professes to practise medicine but does not possess a qualification recognised by the Government should within a specified date apply to the Government for license to practise. Every application should be accompanied by a certificate from the Tahsildar of the locality showing that the applicant has been practising for at least one year. Each applicant should state what system or systems he is supposed to practise. He should also remit a suitable fee to meet the cost of this measure. The next step is for all these applicants to elect six physicians from among themselves (for each system). All the remaining applicants should appear before these six, who should form a Board of Examiners and get certificates that they really know what they profess to know.

As an alternative the Government may nominate the Board of Examiners.

All the successful candidates should be brought to a register and none who is unregistered should be allowed to practise.

After this, any one wishing to enter the medical profession, should first get a recognised allopathic qualification and then study for a period of of one year in a recognised and re-organised school of Indian medicine and then only should be allowed to practise. This is the only way to prevent Practitioners of indigenous systems from doing incalculable damage by dabbling in the allopathic system, about which they may know very little. This is also the only way to rejuvenate the indigenous systems which are undoubtedly arrested sciences. This is also the only way to satisfy (without doing harm) the demand of a certain section of the people for treatment according to the indigenous system.

Regarding the unqualified midwives every one of them who is willing should be given proper training in midwifery with emphasis on asepsis and those who are not willing should be debarred from practising as midwives.

If prohibition will put crores of Rupees in the poor man's pocket, these Reforms will save double that amount in terms of cash, efficiency, and longevity. There will be tremendous opposition from vested interests and the credulous lay public inspired by these vested interests. The surgeon's knife is drastic. But drastic maladies require drastic methods.

Will the Ministry have the courage to put through the above or similar measures to put down quackery ? Time will show.

G. DURAI RAJ, M.B.,B.S.

Koilpatti.

INSULIN
MULFORD

SOLE IMPORTERS
INDIA, BURMA, CEYLON.
VOLKART BROS.
BOMBAY, KARACHI, MADRAS, CALCUTTA, COLOMBO

SHARP & DOHME

SUCCESSORS TO H. K. MULFORD CO.
PHILADELPHIA—BALTIMORE, U. S. A.

SCIENTIFIC ENZYME DIGESTION

RICH SELECTED ENGLISH MILK
Pancreatised

SELECTED ENGLISH WHEAT
Dextrinised and Pancreatised

PREDIGESTED MILK
(25% Protein Conversion)

PREDIGESTED WHEAT
(25% Starch Conversion)

Powdered by the
COW & GATE
Improved
Roller Process

Peptalac

REGD.

THE NEW INSTANT PREDIGESTED FOOD

SIX OUTSTANDING ADVANTAGES

1 PEPTALAC is "made in a minute" by the simple addition of hot water giving in an instant a digested milk food of high digestibility.

2 PEPTALAC is fool-proof and requires neither technique, skill nor addition of milk. It renders obsolete the method of peptonisation wherein milk had to be held at a temperature 117°F. for 20-30 minutes under carefully controlled conditions.

3 PEPTALAC is guaranteed to have been pancreatised and the essential components of starch and milk proteins broken down to sugars, peptones, and amino-acids. With other methods of peptonisation this cleavage is uncertain and unreliable and the milk which is added is not predigested.

4 PEPTALAC is a safe and practically sterile powder. In the old methods of peptonisation, the milk was predigested at a temperature which is also favourable to the growth of organisms, thus resulting in a final product teeming with bacteria. Reconstituted PEPTALAC is free from pathogenic organisms and practically sterile.

5 PEPTALAC is therefore invaluable for infants, young children, the aged, convalescents, and the weak in health, who are prone to contract milk-borne diseases from ordinary milk or preparations made with it.

6 PEPTALAC is pleasing to the most fastidious palates—salt or chocolate may be added for further flavouring if desired.

Supplies can be obtained from the following Special Distributors:—

WILFRED PEREIRA, MADRAS. BANGALORE PHARMACY, BANGALORE.

MANUFACTURERS OF THE Cow & Gate Milk Food CELEBRATED COW & GATE MILK FOOD

COW & GATE LTD., GUILDFORD, ENGLAND

***Agents for S. India:*—CARR & CO., LTD., First Line Beach, MADRAS,**

ASSOCIATION NOTES.

SOUTH INDIAN MEDICAL UNION.

Minutes of the meeting of the Council of the Union held on Friday the 22nd October 1937 at 6 p. m. at 32, Broadway, Madras.

The following members were present :—

Dr. E. V. Srinivasan.
,, T. Satakopan.
,, M. Krishnamoorthy.
,, P. Govinda Rao.
,, V. C. Sudarsanam.

Dr. E. V. Srinivasan, M B , C.M , was in the chair.

1. The Financial Statement for the month of September 1937 was presented and approved.

2. The following practitioners were enrolled as members of the Union.

Dr. J. Jacob, M.B., B.S.
,, K. N. Karunakaran, L.M.P.
,, P. Balakrishnan, M.B , B.S.
,, S. R. Manel, M.B., B.S.
,, A. V. Avadhani, L.M.P.
,, M. Ramachandran, L.M.P.
,, P. Srinivasan, L.M.P.
,, V. Rama Iyengar, B.A., L.M. & S.
,, P. Krishna Doss, L.M.P.
,, T. Kanakaraju, L.M & S.
,, N Satyanarayana Rao, B A , L M. & S.
,, V. Viswanathan, L.M.P., L.C.
,, N. Gopalan Nair, L.M P.
,, Y. Dhanapathy M B , B.S.
,, C. T Rangaswami, M.B , B.S., F.R.F.P.S.
,, J. C Thivy, M.B., B.S.

3. The letter from Dr. M. Subramania Iyer, expressing inability to accept the nomination for Trusteeship of the Health Propaganda Board, was placed before the meeting and it was accepted.

Dr. V. C. Sudarsanam was nominated as a Trustee to the Health Propaganda Board.

4. The Council approved of the suggestion of the General Secretary that the bill outstanding with Messrs. Solden & Co., should be settled at an early date.

With a vote of thanks to the chair the meeting terminated.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION, PALAMCOTTAH.

(Affiliated to the Indian Medical Association).

The Tinnevelly District Medical Association held its monthly meeting on Saturday the 25th of September 1937, at Sankarankoil, a holy place of the District. Members numbering 45 were present from all parts of the District.

The Secretary Dr. K. Rama Ayyar, M.B.B.S., (Andhra)., read the minutes of the monthly meetings held at Courtallam and Headquarters in July and August respectively, which were passed.

1. After detailed and full discussion the following resolution was passed unanimously :—

" The object of the Indian Medical Association started on the model of the British Medical Association, being to develop medical and allied sciences, to improve the public health, to maintain the honour and dignity as well as the interests of the Medical Profession, to bring about the unification of all ranks of the Medical Profession in India and to improve esprit d' corps among them,

The object of the Tinnevelly District Medical Association being the same as above,

And the Indian Medical Association being the only Association in India which provides a common platform for all classes and strata of allopathic medical practitioners practising in India,

The Monthly meeting of the Tinnevelly District Medical Association, assembled at Sankarankoil, on the 25th of September 1937, hereby unanimously resolves, after full discussion, that the Tinnevelly District Medical Association should be converted into a proper Branch of the Indian Medical Association with effect from the 1st October next."

CALOGLAND

STIMULATES

GASTRIC-HEPATIC ACTIVITY

Under the influence of Calogland digestion is improved, liver activity stimulated and the flow of bile is improved both in quantity and quality. Elimination of waste matter is more complete and thus the absorption of toxic matter from the gastro intestinal region is reduced.

COMPOSITION:—Calomel, Stomach Extract, Liver Extract, Oil of Peppermint.

DOSE:—3 to 6 tablets daily.

Bottles of 48 Tablets.

The Anglo-French Drug Co. (Estn.) Ltd.,
P. O. Box 460 — BOMBAY.

CARDEON

THE NEW HEART TONIC

COMPOSITION

Vaso-motor nucleosides, Chlorophyll,
Cardiac extracts, Calcium and Magnesium.

TONIFIES and PROTECTS THE HEART

2, 4 or 6 tablets per day
taken between meals.
Bottles of 48 tablets.

The Anglo-French Drug Co. (Estn.) Ltd.,
P. O. Box 460 BOMBAY.

2. The following resolutions were also passed unanimously :—

(*a*) An extra subscription of One Rupee per head be levied in consideration of the conversion of our Association into a Branch of the Indian Medical Association to meet the Association expenses.

(*b*) The Tinnevelly District Medical Association strongly supports the Bill to amend the Madras Medical Registration Act of 1914 proposed to be moved by Dr. P. S. Srinivasan, M.L.A., in the current Session of the Madras Legislative Assembly, and urges on the Minister for Public Health and the Legislative Members to help in passing the same at an early date.

(*c*) In view of the fact that there has been a persistent demand for the last 25 years from the different Medical Associations and the Medical School students in this country, and in view of the fact that such a change is imperatively necessary to set up a recognised and efficient standard of medical education, this meeting urges on the Minister for Public Health to make the I. Sc., the minimum educational qualification for eligibility for admission into the Medical Schools under the control of the Government of Madras."

THE MEDICAL PRACTITIONERS' ASSOCIATION, NUZVID.

An ordinary meeting of the above Association was held at Veeravalli on Sunday the 26th September 1937 in the Local Board Ely. School at 3 p.m, when Dr G. Venkatakrishnayya, Rural Medical Practitioner, Atkur presided. After the secretary Mr. N. Rama Rao's reading of minutes of the previous meeting which were duly adopted, the meeting commenced with discussion over several subjects of which were cases of acute intestinal obstruction with a few interesting features regarding diagnosis and results of treatment both operative and non-operative as experienced by each of the individual members.

Mr. S. Hanumantha Rao demonstrated a case of Sun-burn in an Anglo-Indian resulting in a peculiar exfoliative dermatitis which was wrongly diagnosed and treated as due to Syphilis.

A paper was then read by Dr. N. Rama Rao on "Female Sex Endocrinology".

Dr. S. Hanumantharao read his clinical notes on a case that simulated Gas gangrene in a multiparous female after instrumental delivery of a still born child (at full term) and ultimately how the case proved fatal in spite of specific measures taken. Lively discussion took place. The members were entertained with refreshments by Dr. S. Hanumantharao, the local practitioner and the meeting came to a close by 6-30 p.m.